Patient Registration

Please circle: Dr. Mr. Mrs. Ms. Miss

Name:_____ Date:_____/_____/_____

Address:_____

City:_____ State:_____ Zip:_____

Patient's Age:_____ Date of Birth:_____

Occupation:_____ Employer:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Email:_____ Cell Phone: (_____)_____

If married, spouse's name:_____

Spouse's employer:_____

Children living at your home:

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

If under 18 years old or parent's are financially responsible:

Father's Name:_____ Father's employer:_____

Mother's Name:_____ Mother's employer:_____

If you are a student, name of school or college:_____

Emergency contact:_____ Phone(_____)_____

Who may we thank for referring you?_____

Do you have any hobbies?_____

General History

Primary Care Physician:_____

Medications:_____

Please circle those that apply to you:

High Blood Pressure	Thyroid Disease	Pregnant	Ear, nose, throat problems
Low Blood Pressure	Neurological Disease	Cigarette Smoker	Chronic Fatigue
Heart Problems	Gastrointestinal Disease	Alcohol Abuse	Chronic Pain
Diabetes	Musculoskeletal Disease	Substance Abuse	Weight Changes
Respiratory Disease	Skin Disease	Allergies	Depression
Mental Disease	Cancer	Sinus Problems	Anxiety Disorder
Immune Disease	Migraine	Hay Fever	Stroke
Endocrine Disease	Other Headache	Multiple Sclerosis	Urinary/Genital Disease

Other:_____

Allergies or sensitivities to medications:_____

Family History

Please circle those that apply:

Cataract	Diabetes
Glaucoma	Heart Disease
Macular Degeneration	Stroke
Retinal Detachment	Other:_____

Personal Eye Information

Date of last eye exam:_____ Doctor's Name:_____

Please circle those that apply to you:

Full time glasses wear	LASIK surgery	Glaucoma	Eye injury
Glasses wear only for near	Retinal surgery	Cataract	Spots/flashes
Glasses wear only for far	Cataract surgery	Double vision	Light sensitivity
Soft contact lens wear	Other eye surgery	Eye pain	Itchy/burning
Rigid contact lens wear	Keratoconus		

Authorization:

I certify that I have read and answered the above information to the best of my ability. I authorize my insurance to pay directly to the doctor. I understand that my insurance may pay less than the actual bill for goods and services, and that I am responsible for the balance of those fees. My signature below serves as a signature on file for billing and that I have been given an opportunity to review the HIPAA Privacy Act as it applies to my care at Factoria Eye Clinic.

Signature of Patient:_____ Date:_____